Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.[insert]** or by calling **1-800-[insert]**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com or call 1-800-[insert]** for a list of	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network

	participating providers.	**provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

OMB Control Numbers 1545-XXXX, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care	Primary care visit to treat an injury or illness	$35 co-pay/visit	40% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
provider's office or clinic	Specialist visit	$50 co-pay/visit	40% co-insurance	----------none----------
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture	40% co-insurance for chiropractor and acupuncture	----------none----------
	Preventive care/screening/immunization	No charge	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	$10 co-pay/test	40% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	$50 co-pay/test	40% co-insurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www. [insert].	Generic drugs	$10 co-pay/ prescription (retail and mail order)	40% co-insurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% co-insurance (retail and mail order)	40% co-insurance	----------none----------
	Non-preferred brand drugs	40% co-insurance (retail and mail order)	60% co-insurance	----------none----------
	Specialty drugs	50% co-insurance	70% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------none----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------none----------
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	----------none----------
	Emergency medical transportation	20% co-insurance	20% co-insurance	----------none----------
	Urgent care	20% co-insurance	40% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	----------none----------
	Physician/surgeon fee	20% co-insurance	40% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay/office visit and 20% co-insurance other outpatient services	40% co-insurance	----------none----------
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	----------none----------
	Substance use disorder outpatient services	$35 co-pay/office visit and 20% co-insurance other outpatient services	40% co-insurance	----------none----------
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	----------none----------
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	----------none----------
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	----------none----------
	Rehabilitation services	20% co-insurance	40% co-insurance	----------none----------
	Habilitation services	20% co-insurance	40% co-insurance	----------none----------
	Skilled nursing care	20% co-insurance	40% co-insurance	----------none----------
	Durable medical equipment	20% co-insurance	40% co-insurance	----------none----------
	Hospice service	20% co-insurance	40% co-insurance	----------none----------
If your child needs dental or eye care	Eye exam	$35 co-pay/ visit	Not Covered	Limited to one exam per year
	Glasses	20% co-insurance	Not Covered	Limited to one pair of glasses per year
	Dental check-up	No Charge	Not Covered	Covers up to $50 per year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.[insert]
- Weight loss programs

Your Rights to Continue Coverage:

**** Individual health insurance sample –**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

OR

**** Group health coverage sample –**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Questions: Call **1-800-[insert]** or visit us at **www.[insert].com.**

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.[insert]** or call 1-800-[**insert**] to request a copy.

Insurance Company 1: Plan Option 1

Coverage Examples

Coverage for: Individual + Spouse | **Plan Type:** PPO

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for

s: $7,540

)	$2,700
	$2,100
	$900
	$900
	$500
	$200
	$200
e	$40
	$7,540

Patient pays:

Deductibles	$700
Co-pays	$30
Co-insurance	$1320
Limits or exclusions	$0
Total	**$2,050**

- **Amount owed to providers:** $4,100
- **Plan pays** $2,480
- **Patient pays** $ 1,620

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$800
Co-pays	$500
Co-insurance	$240
Limits or exclusions	$80
Total	**$1,620**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [insert].

Questions: Call **1-800-[insert]** or visit us at **www.[insert].com**.
If you aren't clear about any of the bolded terms used in this form, see the Glossa
at **www.[insert]** or call 1-800-[**insert**] to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to

accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.